REQUIREMENTS FOR THIRD PARTY LIABILITY

IDENTIFYING LIABLE RESOURCES

1. Frequency of data exchanges. 433.138 Determining Liability of Third Parties.

(d)(1) - State Wage Information Collection Agencies (SWICA): Quarterly, but agencies have daily on line query capability.
(d)(2) - Private health insurers: Biannually.
(d)(3) - IV-A: Part of the SWICA exchange, quarterly.
(d)(4) - Workers compensation: Quarterly.
- Motor vehicle: Annual.
- Trauma codes: Monthly.

2. Timeliness of follow-up.

433.138(g)(1)(ii) SWICA records carry an indicator of whether an employer offers insurance to any employe. If an attempted match record hits on a SWICA record having an affirmative indicator, a request letter is sent to the casehead for contact with their worker. Clients who receive the request letter are listed, and these lists are sent by overnight mail to economic support agency workers, usually within 24 hours of the generation of the hit report. (A large mailing of a higher priority may cause a delay of up to 24 additional hours). If no contact by the client occurs within ten days, the worker initiates contact with the client. The worker must reach closure within 30 days of receipt of the list of clients to whom the contact requests were sent, or by the next eligibility review date, whichever is earlier. Closure means submittal of an insurance reporting form, DCS 2096, to the fiscal agent or documenting in the file that there is no insurance.

The fiscal agent completes data entry within three working days of receipt of the DCS 2096, and creates a 12 calendar day pend if no MMIS eligibility record is found. Since an eligibility record will be found in cases in which the DCS 2096 results from the SWICA match, timeliness standards will be met, while still allowing for the delayed creation of new records. Therefore, SWICA-derived insurance information is added to the file in less than 45 days of the match.

433.138(g)(2) Workers compensation data matches use a two year rolling history file of the Trauma Claims Report, matching it to the worker's compensation open case file. Matched records of a Medical Assistance recipient for whom a trauma claim has been paid and who also has a workers compensation claim are reported to the state. Matches identify all trauma-involved Medical Assistance claims paid and the nature of the recipient's workers compensation-related injury. The Medical Assistance claim diagnosis is compared to the workers compensation report of injury site. The date(s) of Medical Assistance paid service(s) and date of the workers compensation injury are also compared. If similar, a telephone contact is made with the agency responsible for collection to determine whether or not the case is known and if action has already been taken. To date, there have been no cases in which recoverable costs have been incurred by Medical Assistance that were not already known and acted upon by agencies, so it is difficult to report normal time frames for action. Based upon experience in reviewing matched reports, however, if a previously unknown case were identified, action would be taken in perhaps half of the sixty days specified by the regulation. Except for this data match, workers compensation cases are treated like any other personal injury case, including Trauma Claims Report investigations. These are effective investigations and that may account, in part, for the meager results of the workers compensation data match. Refer to paragraph (4), below, for further information.

Eff. 7-1-96 433.138(g)(2) The Insurance Information Disclosure Requirement is a program that requires health insurers to disclose information on the Wisconsin residents whom they insure. This information is used by Wisconsin to match against the Medicaid eligibility files to identify Medicaid recipients with insurance coverage. Although insurance companies are only required to submit information semi-annually, most companies provide data on a monthly basis. This information provides the best source of actual insured and coverage provisions.

433.138(g)(2)(ii) The motor vehicle data exchange agreement allows for matching recipient claims data with the Department of Transportation's accident files for potential hits.

3. Follow through on motor vehicle data match:

433.138(g)(3) Reports are produced by the Medicaid Evaluation Program from an annual match completed with DOT. Potential cases are determined from match criteria based on the type of accident and recipient claims paid on or after the date of the accident. These reports are forwarded to the Coordination of Benefits Unit to determine whether or not an injury case is open on the identified occurrence/recipient. If so, no further handling is done on those cases. If not, a personal injury file is opened by contacting the recipient involved to obtain additional information on the accident. These cases are treated like any other personal injury case.

4. Trauma diagnosis codes:

433.138(g)(4) On a monthly basis, the fiscal agent prepares a report of paid hospital claims with a provider billed amount of $350 or more that indicate one or more predetermined diagnosis codes. All codes in the 800-999 range, except those that identify drug and alcohol abuse, and others outside of the mandated range determined to potentially relate to an injury may cause listing on this report.

Counties and tribes are responsible for collection on cases in which they have determined eligibility and the Coordination of Benefits Unit, BHCF, is responsible for collection of SSI and other non-locally certified cases, such as Katie Beckett cases. A copy of the trauma claims report is sent by the fiscal agent to the responsible agency with a request for reporting of cases that have already been identified and on which collection action is in progress.

The fiscal agent completes limited investigation on these to determine third party involvement. Investigative action is discontinued if the responsible agency reports knowledge of and action on the case. The fiscal agent sends a questionnaire and cover letter to the injured party (or caretaker) asking for information about the existence of a liable party. Replies are assessed to determine whether or not an actionable condition exists.

A follow-up mailing to non-responders is made after 30 days. If no response is obtained within 60 days of the follow-up attempt, telephone contact with the injured person or a family member is attempted where possible or collateral investigation is made by contacts with providers to obtain information.

This action is supported by an administrative rule prohibiting providers from releasing information to attorneys or adjusters without notice to the Coordination of Benefits Unit. If a collection opportunity is lost because providers have not complied, the providers are at risk for associated payments made to them. The provider notices are sent to the fiscal agent and integrated with the investigative action on trauma claims reports.

Between the trauma claims investigations and the provider referrals, the incidence of closure on trauma claim report cases is over 90 percent. The remainder, an average of about 40 per month, are resolved as follows if closure cannot be achieved:

- Refer to county agency after six months if there is a UB 92 occurrence code equaling auto, auto no fault, workers compensation or tort and if the billed amount is greater than $1,000.
- Refer to agency after six months if the diagnosis code is in the E or V series, the occurrence code, if any, is not crime victim and the billed amount is greater than $1,000.
- Refer to agency after six months if the diagnosis code is in the 800-957 range, the occurrence code, if any, is not crime victim and the billed amount is greater than $2,500.

Quarterly reports indicating the frequency of actionable and non-actionable results of investigation by diagnosis code and UB 92 occurrence code are produced.

On receipt of information on the actionability of a case, the agency responsible for collection action must immediately provide certified mail notice of subrogation rights at least to the attorney for the claimant and/or to any insurance adjustor who has been identified. With this action a case file is opened. A payment record is ordered from the fiscal agent at this time and, following receipt, the claim amount is determined and the attorney or adjustor is advised of it.

Action timeliness is determined by the provision of notice to the parties, not by transmittal of claim amount information, because upon receipt of notice by the parties the right of recovery is preserved. Normally, notice is provided within a week of the identification of a case by an agency and within two weeks of identification by the fiscal agent.

Information related to this type of liability is not carried on the MMIS file. It cannot be used as a reason to cost avoid and it has no other use where MMIS is concerned. The collection case file contains all information relevant to management of the case.